

6427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G262 5/11/60 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>R.R.D.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Vance</u> Middle <u>Bayne</u> Last		4. DATE OF DEATH <u>May</u> 2 Day <u>1960</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cynacellon</u>	
11. BIRTHPLACE (State or foreign country) <u>Lincoln England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Vance Bayne</u>		14. MOTHER'S MAIDEN NAME <u>Anne McGuffee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MR. DELBERT TREMBLY</u>		Address <u>WILMINGTON, DEL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> DUE TO <u>420J</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lived alone - Didn't use MD's</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>

TO DEDUCE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

6428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MILTON Middle M. Last DALE				4. DATE OF DEATH Month May Day 10 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3 1879	
9. AGE (In years last birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural mail carrier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Mail		11. BIRTHPLACE (State or foreign country) Whaleyville, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter Dale		14. MOTHER'S MAIDEN NAME Jennie Mumford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XXX		17. INFORMANT Herman Truitt Whaleyville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease & Coronary Arteriosclerosis (c) Severe Myocardial Anterior Infarction							INTERVAL BETWEEN ONSET AND DEATH minutes 12 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Left Ventricle & Bilateral Hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 19 48 , to May 10 , 19 60 , that I last saw the deceased alive on May 10 , 19 60 , and that death occurred at 2:00 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Herman A. Kullback M.D. _____ PHYSICIAN'S NAME (Type) Birden, M.D.							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION Cremation		22b. DATE THEREOF May 14/60		22c. NAME OF CEMETERY OR CREMATORY Silverbrook		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville, Del.				24a. REC'D BY REGISTRAR DATE MAY 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

Reg. Dist. No.

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 309, Federal Bureau of Investigation, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Memphis, Tennessee	
10. OCCUPATION Attorney		11. EDUCATION High School Graduate		12. RELIGION Methodist	
13. MARITAL STATUS Single		14. PREVIOUS MARRIAGES None		15. SOCIAL SECURITY NUMBER [REDACTED]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF PHYSICIAN [Signature]	
19. SIGNATURE OF CORONER [Signature]		20. SIGNATURE OF JUDGE [Signature]		21. SIGNATURE OF CLERK [Signature]	
22. SIGNATURE OF REGISTRAR [Signature]		23. SIGNATURE OF ASSISTANT REGISTRAR [Signature]		24. SIGNATURE OF CLERK [Signature]	
25. SIGNATURE OF CLERK [Signature]		26. SIGNATURE OF CLERK [Signature]		27. SIGNATURE OF CLERK [Signature]	
28. SIGNATURE OF CLERK [Signature]		29. SIGNATURE OF CLERK [Signature]		30. SIGNATURE OF CLERK [Signature]	
31. SIGNATURE OF CLERK [Signature]		32. SIGNATURE OF CLERK [Signature]		33. SIGNATURE OF CLERK [Signature]	
34. SIGNATURE OF CLERK [Signature]		35. SIGNATURE OF CLERK [Signature]		36. SIGNATURE OF CLERK [Signature]	
37. SIGNATURE OF CLERK [Signature]		38. SIGNATURE OF CLERK [Signature]		39. SIGNATURE OF CLERK [Signature]	
40. SIGNATURE OF CLERK [Signature]		41. SIGNATURE OF CLERK [Signature]		42. SIGNATURE OF CLERK [Signature]	
43. SIGNATURE OF CLERK [Signature]		44. SIGNATURE OF CLERK [Signature]		45. SIGNATURE OF CLERK [Signature]	
46. SIGNATURE OF CLERK [Signature]		47. SIGNATURE OF CLERK [Signature]		48. SIGNATURE OF CLERK [Signature]	
49. SIGNATURE OF CLERK [Signature]		50. SIGNATURE OF CLERK [Signature]		51. SIGNATURE OF CLERK [Signature]	
52. SIGNATURE OF CLERK [Signature]		53. SIGNATURE OF CLERK [Signature]		54. SIGNATURE OF CLERK [Signature]	
55. SIGNATURE OF CLERK [Signature]		56. SIGNATURE OF CLERK [Signature]		57. SIGNATURE OF CLERK [Signature]	
58. SIGNATURE OF CLERK [Signature]		59. SIGNATURE OF CLERK [Signature]		60. SIGNATURE OF CLERK [Signature]	
61. SIGNATURE OF CLERK [Signature]		62. SIGNATURE OF CLERK [Signature]		63. SIGNATURE OF CLERK [Signature]	
64. SIGNATURE OF CLERK [Signature]		65. SIGNATURE OF CLERK [Signature]		66. SIGNATURE OF CLERK [Signature]	
67. SIGNATURE OF CLERK [Signature]		68. SIGNATURE OF CLERK [Signature]		69. SIGNATURE OF CLERK [Signature]	
70. SIGNATURE OF CLERK [Signature]		71. SIGNATURE OF CLERK [Signature]		72. SIGNATURE OF CLERK [Signature]	
73. SIGNATURE OF CLERK [Signature]		74. SIGNATURE OF CLERK [Signature]		75. SIGNATURE OF CLERK [Signature]	
76. SIGNATURE OF CLERK [Signature]		77. SIGNATURE OF CLERK [Signature]		78. SIGNATURE OF CLERK [Signature]	
79. SIGNATURE OF CLERK [Signature]		80. SIGNATURE OF CLERK [Signature]		81. SIGNATURE OF CLERK [Signature]	
82. SIGNATURE OF CLERK [Signature]		83. SIGNATURE OF CLERK [Signature]		84. SIGNATURE OF CLERK [Signature]	
85. SIGNATURE OF CLERK [Signature]		86. SIGNATURE OF CLERK [Signature]		87. SIGNATURE OF CLERK [Signature]	
88. SIGNATURE OF CLERK [Signature]		89. SIGNATURE OF CLERK [Signature]		90. SIGNATURE OF CLERK [Signature]	
91. SIGNATURE OF CLERK [Signature]		92. SIGNATURE OF CLERK [Signature]		93. SIGNATURE OF CLERK [Signature]	
94. SIGNATURE OF CLERK [Signature]		95. SIGNATURE OF CLERK [Signature]		96. SIGNATURE OF CLERK [Signature]	
97. SIGNATURE OF CLERK [Signature]		98. SIGNATURE OF CLERK [Signature]		99. SIGNATURE OF CLERK [Signature]	
100. SIGNATURE OF CLERK [Signature]		101. SIGNATURE OF CLERK [Signature]		102. SIGNATURE OF CLERK [Signature]	



THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE PROPERLY VERIFIED. ANY FALSIFICATION OF THIS CERTIFICATE IS A CRIME UNDER THE LAWS OF MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06387

6425

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Pocomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fletcher</u> First Middle Last		4. DATE OF DEATH <u>May 22, 1960</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dryden</u>		14. MOTHER'S MAIDEN NAME <u>Harriet ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-6659A</u>	
17. INFORMANT <u>Edna Dryden</u> Address <u>7 Gray St Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease, Severe</u> DUE TO <u>Arteriosclerosis & Atherosclerosis, Mod. Severe</u> (c) <u>many years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Prostatitis & Chronic Gastritis, Moderate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1949</u> to <u>23 April 1960</u> , that I last saw the deceased alive on <u>23 April 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N. E. Sartorius, Jr.</u> M.D.		DATE SIGNED <u>Pocomoke City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius, Jr., M.D.</u>		<u>114 Market St., Pocomoke City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 27, 1960</u>		22b. DATE THEREOF <u>May 27, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - new church, Va.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JUN 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

1888

My name is William D. Brown, Jr.
I am of the County of Worcester
State of Massachusetts
I hereby certify that on the 21st day of
May 1888, at the residence of the deceased
at the village of Uxbridge, in the County of
Worcester, State of Massachusetts, died
William D. Brown, Jr., of the County of
Worcester, State of Massachusetts, aged
about 45 years.

The cause of death was
Typhoid Fever, contracted at
the residence of the deceased.
The deceased was
born at the village of Uxbridge,
County of Worcester, State of
Massachusetts, on the 21st day of
May 1843.
He was a native-born American,
and was a member of the
Congregational Church of
Uxbridge, Massachusetts.
He was a farmer by occupation,
and was well known in the
community in which he lived.
He was a man of good character,
and was highly respected by
all who knew him.
He was a member of the
Worcester County Agricultural
Society, and was a member of
the Uxbridge Fire Company.
He was a man of good family,
and was a member of the
Worcester County Agricultural
Society, and was a member of
the Uxbridge Fire Company.
He was a man of good family,
and was a member of the
Worcester County Agricultural
Society, and was a member of
the Uxbridge Fire Company.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6429

CERTIFICATE OF DEATH

06388

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First D. Middle Ryal Last Hudson				4. DATE OF DEATH Month May 19, 1960 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1897	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John T. Hudson				14. MOTHER'S MAIDEN NAME Martha Esham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XX		17. INFORMANT Mrs. Grace Hudson Bishop, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis & myocardial infarction DUE TO 420-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO Had a "heart attack" 1 wk ago (treated) (c) By Dr. Robins, Baltimore, Md. INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Attended by Dr. Robins (see above) that I last saw the deceased alive on 19 , and that death occurred at 10:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Selbyville, Del. DATE SIGNED 20 May '60							
ACTUAL SIGNATURE Earl B. McFadden M.D.				PHYSICIAN'S NAME (Type) Earl B. McFadden			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/60		22c. NAME OF CEMETERY OR CREMATORY I. O. O. F.		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville, Del.				24a. REC'D BY REGISTRAR DATE MAY 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06389

Reg. Dist. No.

6423

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hotel Commander</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 0210.2 d. STREET ADDRESS <u>23 State Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Rose</u> First <u>C</u> Middle <u>Jameson</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1910</u>		9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sect.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel, Mgr</u>				11. BIRTHPLACE (State or foreign country) <u>Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert B. Fitzsimmons</u>						14. MOTHER'S MAIDEN NAME <u>Grace McFeaters</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>N</u>		17. INFORMANT <u>Mrs. Meredith L. Elder- Sister- Clairton, Pa.</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>W. Lovett</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>May 29 1960</u>					
EXAMINER'S NAME (Type) <u>W. Lovett</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>				22d. LOCATION (City, town, or county) <u>Bryantown, Maryland</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>						24a. REC'D BY REGISTRAR <u>JUN 1 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

TO DEDUCT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06390

6430

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last JONES		4. DATE OF DEATH Month May Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Clay Pilchard		14. MOTHER'S MAIDEN NAME Susan Jane Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Cassius C. Jones, Stockton, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema 443 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Degenerative Heart Disease DUE TO (c) 1 Hour years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Hypertension ② Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1960 to May 22, 1960 that I last saw the deceased alive on May 21, 1960 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Stockton, Maryland DATE SIGNED 5/23/60			
ACTUAL SIGNATURE Charles W. Trader, M.D.			
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D., 302 Market St., Pocomoke City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-24-60	
22c. NAME OF CEMETERY Gumby Presbyterian		22d. LOCATION (City, town, or county) (State) Stockton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson		24a. REC'D BY REGISTRAR DATE MAY 26 '60	
ADDRESS Pocomoke City, Md.		24b. REGISTRAR'S SIGNATURE C. S. S. S. S.	

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
HENRY ALVA LIGON		M		60		JAN 10 1897		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
JAN 10 1957		10:00 AM		NEW YORK		NEW YORK		NEW YORK		NEW YORK		HEART DISEASE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. LIGON		J. H. LIGON		J. H. LIGON		J. H. LIGON		J. H. LIGON		J. H. LIGON		J. H. LIGON		J. H. LIGON	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
JAN 10 1957		10:00 AM		NEW YORK		NEW YORK		NEW YORK		NEW YORK		HEART DISEASE		NATURAL	

6431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle KATHERINE Last MATTLAGE		4. DATE OF DEATH Month May Day 18 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 2 Days 6 Hours 18 Min.	11. IF UNDER 24 HRS. Months 2 Days 6 Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George Mattlage		14. MOTHER'S MAIDEN NAME Clara Spellmeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Florence Turner, Redbank, New Jersey		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. PRIMARY CARCINOMA OF PANCREAS DUE TO 18 MONS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 6 MONS 18 MONS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/2 , 19 56 to 5/18 , 19 60 , that I last saw the deceased alive on 5/17 , 19 60 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. D. Hamilton		ADDRESS (Street, city or town, state) 212 MARKET ST.	
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON		DATE SIGNED 5/18/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-60	
22c. NAME OF CEMETERY OF EXPOSITION Presbyterian		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Dutton		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR MAY 23 '60		24b. REGISTRAR'S SIGNATURE Calvin S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6424 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G264 6-6-60 et

66392
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Wilmington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> 46X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>7 Parkside Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Michael Francis Neill</u>				4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 - 1918</u>	9. AGE (In years for birthday) <u>41</u> Yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Redevelopment Insurance + Insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>			
11. BIRTHPLACE (State or foreign country) <u>Waldwood, NJ</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John O'Neill</u>				14. MOTHER'S MAIDEN NAME <u>Rose Floyd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>342-07-050</u>			
17. INFORMATION <u>Wilmington</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Adornary occlusion (Probably)</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> c. stating the underlying cause lost. <u></u> DUE TO <u></u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N.E. Sartorius</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 1st - All Saints Cemetery</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Wilmington Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Buehge Berlin Md</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. H...</u>	

MEDICAL CERTIFICATION

TO DIE BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. NAME OF DECEASED		4. SEX	
5. AGE		6. RACE	
7. OCCUPATION		8. MARITAL STATUS	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. TIME OF DEATH		12. CAUSE OF DEATH	
13. MANNER OF DEATH		14. SIGNATURE OF EXAMINER	
15. SIGNATURE OF WITNESS		16. SIGNATURE OF CORONER	
17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF CLERK		20. SIGNATURE OF NOTARY	
21. SIGNATURE OF CHURCH		22. SIGNATURE OF FUNERAL HOME	
23. SIGNATURE OF BURIAL		24. SIGNATURE OF CREMATION	
25. SIGNATURE OF INTERMENT		26. SIGNATURE OF REINTERMENT	
27. SIGNATURE OF REINTERMENT		28. SIGNATURE OF REINTERMENT	
29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT	
33. SIGNATURE OF REINTERMENT		34. SIGNATURE OF REINTERMENT	
35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT	
39. SIGNATURE OF REINTERMENT		40. SIGNATURE OF REINTERMENT	
41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT	
45. SIGNATURE OF REINTERMENT		46. SIGNATURE OF REINTERMENT	
47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT	
51. SIGNATURE OF REINTERMENT		52. SIGNATURE OF REINTERMENT	
53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT	
57. SIGNATURE OF REINTERMENT		58. SIGNATURE OF REINTERMENT	
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81. SIGNATURE OF REINTERMENT		82. SIGNATURE OF REINTERMENT	
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89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT	
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95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT	
99. SIGNATURE OF REINTERMENT		100. SIGNATURE OF REINTERMENT	

6426

CERTIFICATE OF DEATH

06393
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Williams Edward Wise		4. DATE OF DEATH May 11 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm Work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Williams Edward Wise, Sr.		14. MOTHER'S MAIDEN NAME Grace Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-0964A	
17. INFORMANT Mrs. Beulah Hughes		Address 106 W. Sharpneck ST. Philadelphia, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Hypertensive Cardio-vascular Disease DUE TO (c) Glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-8, 1960 , to 5-9, 1960 , that I last saw the deceased alive on 5-9, 1960 , and that death occurred at 7:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin Md	
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. M.D.		DATE SIGNED 5/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5, 15/60	
22c. NAME OF CEMETERY OR CREMATORY Wardtown, Cem.		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton		ADDRESS New Church, Va.	
24a. REC'D BY REGISTRAR MAY 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

DATE OF DEATH

1933

NAME

AGE

SEX

RACE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH